



Prescription Drug Coverage Determination Form
Growth Hormone Receptor Antagonist
Somavert® (pegvisomant)

Please fax the completed form to Mercy Health Plans' Pharmacy Department
at 314-214-8201 or 1-800-466-9854.

Patient Information

Patient Name: _____ Date of Birth: _____
Subscriber ID#: _____
Address _____ City _____ State _____ Zip Code _____

Physician Information

Name: _____ Specialty: _____ Tax ID#: _____
Office Address _____ City _____ State _____ Zip Code _____
Telephone: _____ Fax: _____ Contact Person _____

Physician Signature (REQUIRED): _____ Date _____

Medication Information (requests for non-formulary agents will be considered for
members having a documented failure or contraindication to preferred agents.)

Medication name: _____ J-code: _____
Dose: _____ Directions: _____
Expected Duration of Therapy: _____

Prior Authorization Criteria:

1. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D? Yes No
Diagnosis: _____ ICD-9 code _____
2. Has the patient received treatment with Somavert® for the past 6 months? Yes No
If yes:
 - Has the patient demonstrated a significant decrease in insulin-like growth factor-1 (IGF-1) level with Somavert® therapy? Yes No
3. Has the patient received any of the following therapies for acromegaly: surgery, radiation therapy, or medical treatment? Yes No
If yes;
 - Did the patient have an inadequate response to therapy, or has the physician considered treatments other than Somavert® for acromegaly but rejected as inappropriate? Yes No
4. Prior to initiation of therapy, did the patient have an insulin-like growth factor-1 (IGF-1) level above the age and gender adjusted normal range? Yes No
5. Will the patient have IGF-1 levels monitored at 6 months intervals after IGF-1 levels stabilize within normal range? Yes No

6. Will the liver function test be monitored as recommended during therapy? Yes No

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): _____

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.